THE HAY GROUP

MEMORANDUM

November 8, 1983

STAT TO: [redacted]

FROM: Edwin C. Hustead

SUBJECT: Review of Government Employees Health Association Benefits and Premiums

Enclosed is our report on the relative value and costs of the benefits provided by the Government Employees Health Association Plan for 1984. We will review this report with the Association Board on November 14. We will also use portions of the report for the employee briefing on November 16.

Enclosure.

THE HAY GROUP

Government Employees Health Association
Analysis of 1984 Benefits and Premiums

The 1984 benefits and premiums for the Federal Employees Health Benefits Program (FEHBP) have been set. The 16% premium increase for the Government Employees Health Association (Association) Plan is comparable to other plans in FEHBP and to increases in the private sector. However, the benefits had to be cut to keep the increase at 16% and a shift in the big six FEHBP plans will result in an enrollee rate increase of 24%.

As a result of these factors the Central Intelligence Agency (CIA) and the enrollees in the Association Plan need to be assured that the 1984 premium and benefit structure are competitive with other health programs.

Hay Associates has reviewed the negotiation file and the premium and benefit structure of other plans and arrived at the following conclusions:

- The benefit structure is generally comparable with other FEHBP plans with certain significant advantages.
- The overall rate increase is reasonable compared to trends in other FEHBP plans and the economy in general.
- The combination of a conservative 1984 rate increase and benefit changes geared to control costs may well lead to high reserves in 1984 that can be used to offset part of any 1985 rate increase.

In addition to the possible excess reserves that may occur next year, there are other measures that the Association can consider to evolve a more competitive program. The current contract will involve Hay in this review and redesign process during 1984.

In the meantime, it is necessary to communicate the situation to the enrollees. We suggest that the Association accentuate the positive aspects of the benefit and premium package. First, the Association still provides one of the best benefit packages at a rate that is competitive with most other plans. In fact, some of the coverage cannot be found elsewhere in FEHBP. Second, the cost control measures introduced for 1984 should have a favorable impact on future rates and benefits.

General Trends in Premium Cost

The dilemma your organization is facing in the health care arena is one of concern and confusion for employees and management alike. Are steadily growing premiums warranted even when benefits are being reduced, and if warranted, what methods are available to combat the problem? This same question is confronting employers in both the public and private sectors; it appears pervasive, affecting groups regardless of their size.

The 1983 Hay/Huggins Noncash Compensation Comparison showed that health care costs continued to rise significantly this year with 67% of the reporting survey base indicating premium increases of 15% or more. The average medical benefits cost increase for each of the past two years has been 25%. Generally, health care expenditures have been increasing at twice the CPI rate, and now represent almost 10% of the Gross National Product. Given this backdrop, the Association's experience is not atypical, however, it is magnified by the "captive audience" aspect of at least a portion of your population.

When we look for explanations of the substantial health care cost rise, we find several avenues to pursue:

- continued medical care inflation;
- lack of consumer pressure on the marketplace;
- an uneducated consumer population;
- the cost of improved technology;
- outmoded plan design; and
- cost shifting from the public sector, for instance Medicare's Diagnosis Related Group reimbursement for hospital care.

Each element contributes directly to the rate increases employers have felt as premium levels are driven by the cost per claim and the incidence of utilization by the group.

What are employers as a whole doing about the problem? Many are taking some of the same steps followed by the FEHBP since 1981, that is, reducing benefits, redesigning plan structure, and shifting more of the premium cost burden to the employee. On a more constructive note, many are taking proactive steps:

- o promotion of the health of their employees;
- o communication programs designed to control costs by promoting consumer awareness of the basis for health care costs and by encouraging better life style patterns;

- o participation in employer coalitions;
- o careful scrutiny of claims for eligibility, accuracy of charges, existence of double coverage, and identification of utilization trends.

Attachment A, taken from the 1983 NCC, details these employer activities.

Comparison of Benefits in FEHBP

FEHBP enrollees have felt the dual sting of benefit reductions and substantial premium increases: the former as a by-product of OPM's reaction to the general escalation in the cost of medical care and its attendant budget implications, the latter exacerbated by the realignment of the "big six". These results have been seen by enrollees in both the traditional insurance type plans and by those choosing the alternative HMO-type plans available under the Program.

Attachment B contrasts key components of the benefit structure of the Association Plan with that offered by other selected FEHBP carriers. Included in the comparison are the two Government wide alternatives (Service Benefit Plan, Indemnity Benefit Plan), single agency offerings (Foreign Service Benefit Plan, GEBA [NSA], and SAMBA [FBI]) and the Government Employees Hospital Association Benefit Plan - Kansas City, and the Postal Supervisors Benefit Plan, an offering structured like your own. The plans are displayed in ascending order based on the annual cost to employees for Self and Family coverage. Mental health benefit provisions are shown in Attachment C.

The range of annual employee premium amounts displayed in the chart runs from $407 to $1692 per year. At first glance, one would expect to see a significant variance in the level of protection available at different prices. However, such is not the case. The less expensive plans do involve more out-of-pocket exposure for an enrollee, but, in most instances not a substantial variation in the benefits provided.

With the reductions for 1984, the Association's benefit structure becomes, overall, typical of other FEHBP offerings in most areas. Specifically:

Hospital Inpatient: With the exception of GEBA all of the charted plans involve a flat dollar out-of-pocket payment. Your Plan's level of reimbursement after that outlay, 100%, is generous, however, your hospital copayment is assessed against each confinement whereas five of the other plans either view the copayment as a part of the Major Medical deductible or assess it once in a calendar year. The Association's inpatient coverage overall is typical.

Surgery: Your Plan's practice of cost sharing imposed for surgery performed on an inpatient basis along with encouragement of outpatient surgery through 100% reimbursement follows the pattern of most FEHBP carriers. You should expect to see cost savings and improved utilization patterns as a result of this benefit change.

Major Medical: The $200 deductible is average. The 80% coinsurance level generally is more generous than less expensive plans and typical of the more expensive offerings.

Dental: The Association Plan provides no dental coverage which is an item many employees perceive as a valued benefit, even though it can be provided for a fairly minimal cost investment.

Stop Loss: Your Plan's catastrophic coverage is a strong point. Not only does it provide protection after $1,000 out-of-pocket, a relatively modest stop loss point, but it includes covered charges for mental and nervous conditions as well. The latter is atypical for FEHBP carriers.

Mental Health: The Association's mental health coverage is among the most comprehensive now available to federal employees, especially on an inpatient basis. Not only is there no lifetime maximum imposed, but out-of-pocket expenses for the enrollee are capped at the $1,000 stop loss level. Only the Foreign Service Benefit Plan approaches the same level of inpatient protection. The outpatient coverage does impose a 50 visit maximum per calendar year, which in most instances, provides more than adequate protection for a covered life. The fact that the 50% out-of-pocket coinsurance expense accrues toward the $1,000 stop loss limit makes the benefit generous.

Comparison of Premiums in FEHBP

Tables one and two show the total annual cost of all of the plans available to agency employees in the Washington area as well as the plans summarized in Attachment B. The Association self only premium is about average but the family premium is in the middle-high range. Because the Association benefits are better than the other plans in the same premium range, the premium is competitive with the higher cost plans. However, the typical employee who does not anticipate unusual expenses can clearly see substantial savings by moving to one of the low cost plans with good benefits.

The two best low cost plans are the "other" GEHA and the Blue Cross low (standard) option. An employee comparing either of these two plans to the Association plan will observe savings of around $800 in premium in the family plan. Unless heavy mental and nervous expenses are incurred, an employee will rarely receive $800 more in benefits from the agency plan than from either of the other two.

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Table 1

1984 Federal Employees Health Benefits Program

Annual Cost Self and Family Option

Insurance Type Plans

	Health Benefits Cost	Annual Associate Dues
Postmasters - Low	$246	$25
Mailhandlers - Low	385	30
Aetna - Low	407	0
Blues - Low	446	0
GEHA-KC	493	35*
Mailhandlers - High	515	30
Postal Supervisors	729	25
Alliance	865	27
SAMBA	872	0
Foreign Service	993	0
NFFE	1003	25
NALC	1190	36
NTEU	1195	30
APWU	1207	35
Government Employees Health Assn.	1248	0
Aetna - High	1308	0
NAGE	1390	25
GEBA	1495	0
Postmasters - High	1631	25
Blues - High	1692	0

D.C. Area Health Maintenance Type Organizations

GHA - Low	$731	0
MD IPA	869	0
Kaiser Georgetown	1049	0
Choice Healthcare	1120	0
GHA - High	1203	0
HealthPlus	1216	0
George Washington	1349	0

*One time only.

Table 2

1984 Federal Employees Health Benefits Program

Annual Cost Self Only Option

Insurance Type Plans

	Health Benefits Cost	Annual Associate Dues
Postmasters - Low	$ 101	$25
Mailhandlers - Low	163	30
Mailhandlers - High	181	30
Blues - Low	187	0
Aetna - Low	191	0
Alliance	225	27
SAMBA	264	0
GEHA-KC	267	35*
Foreign Service	315	0
NFFE	415	25
Government Employees Health Assn.	429	0
Postal Supervisors	492	25
NTEU	523	30
NAGE	551	25
GEBA	574	0
APWU	587	35
NALC	637	36
Postmasters - High	772	25
Blues - High	781	0
Aetna - High	833	0

D.C. Area Health Maintenance Type Organizations

MD-IPA	$ 218	0
GHA - Low	222	0
Kaiser Georgetown	351	0
Choice Healthcare	399	0
GHA - High	404	0
HealthPlus	409	0
George Washington	437	0

*One time only.

Appropriateness of Association Premiums

In 1984 the Association premium increased 16%. This net increase is the same as the average increase of the largest plans in the FEHB Program. In fact, two of the more popular plans, GEHA-KC and Aetna high option, had increases of 30% and 38%, respectively. However, the Association 16% premium increase was effected at the expense of a 9% reduction in benefits. The other plans had already absorbed similar reductions in 1982.

Even though the total Association premium increase is average within the FEHB Program, the increase to the employee is greater than average because of the change in composition of the six largest plans that determine the Government contribution. In 1984, NALC was replaced in the big-six by GEHA-KC. Since GEHA-KC had a much lower premium than NALC, the average Government contribution only went up 10%. As a result, employees in most plans, such as the Association Plan, with average increases, have an above average employee share increase. In summary, the effect on the employee breaks down as follows:

o	Premium increase for 1983 benefit levels-	25%
o	Benefit reduction -	(9%)
o	Big six effect -	8%
o	Total increase -	24%

The premium increase to continue 1983 benefits, before being offset for 1984 benefit reductions, was significantly above the average FEHBP increase as well as the typical private sector increases. The primary reason for this high increase was a deterioration of experience in the last half of 1982. Last year, at the time that rates were set, Mutual of Omaha had expected the early 1982 trends to continue and set the 1983 premium on that basis. However, the monthly payments took a sharp turn upward. Compared to the last half of 1981, overall costs in 1982 were up 37% including an increase in hospital Room and Board cost of 62%. The effect of the unusual claims in that period must not be overlooked. If the last half of 1982 trends are adjusted for the unusual claims, the overall increase would have been 26% rather than 37%.

The way that Mutual of Omaha constructs premiums is to predict each future year's claims as a percentage increase over the last year. Thus, the unusual effect of late 1982 is expected to be repeated in 1983 and 1984. If late 1982 was truly atypical, it is quite possible that experience will be better in late 1983. The effect would be to produce a much lower rate increase in 1985. This effect, coupled with the cost saving measures, could well put the 1985 premium increase at a much lower level than other plans.

The Office of Personnel Management (OPM) concluded that the 1984 premium increase was excessive. While the OPM reasons for this conclusion were not stated, they probably were concerned about over-reaction to a few months of poor experience. Our review of the incurred claims supports the OPM conclusion. If the temporary adverse experience is discounted, it is likely that the 1984 premium will generate excess reserves which can be used to hold down the 1985 premiums.

One important continuing reason for a relatively high rate for the Association is the existence of the very liberal mental and nervous benefits. At one time the Association mental and nervous benefits were typical of the FEHB Program. However, other plans, particularly the Government-wide plans, cut their benefits substantially while the Association plan provisions, particularly in the hospital, stayed at almost full insurance. As a result, 13% to 15% of Association benefits are expended for mental and nervous benefits compared to around 5% for the other FEHB plans.

Table three illustrates the position of the Plan family premiums relative to three of the most popular options in 1981 through 1984. In 1982 the Association family rate rose 50% resulting in a very adverse shift in competitive position. However, as a result of the shifts in other plans in the last two years, the Association's relative position has about returned to the 1981 position. While the Association premium is more than double the lowest cost full benefit plan, GEHA-KC, the premium is well below the most popular plan, the Blues, and has now dropped below the second most popular plan, Aetna.

Table 3

Self and Family Biweekly Rates - 1981 through 1984

	1981	1982	1983	1984
Blues	$30.52	$41.77	$54.50	$65.06
Aetna	15.11	15.66	26.88	50.31
GEHA-KC	10.47	13.00	13.65	18.96
Association	20.49	30.38	38.57	48.00

Alternatives to Consider

Hay will present alternatives for consideration that may be pursued in 1985 to help mitigate continued premium acceleration. We will explore the pros and cons of each alternative as well as the feasibility of the agency implementing the alternatives. We will help the Association to continue their review of the following items:

- limited plan modification;
- introduction of dental benefits;
- creation of a low option;
- a special Government contribution for employees restricted to the Association plan; and
- consideration of other underwriters.

In addition we will explore other areas suggested through discussion with the Association. These will include:

- alternative funding mechanisms, such as minimum premium arrangements;
- purchase of re-insurance to ameliorate the effect of unusual claims; and
- a campaign to educate Association plan enrollees as to effective use of health care.

Hay Associates
11/8/83

Most employers are continuing efforts to control spiraling medical benefits costs (reported at an average cost increase of 25% in each of the last two years). Primary strategies are:

- Changing Plan Design,
- Operating Health Promotion and Communication Programs,
- Conducting Claims Analysis, and
- Organizing Employer Coalitions

Many employers participate in cost containment coalitions to assist them in both operating health and communication programs and in conducting claims analysis.

Plan Design

One-third of the participants have made some "cutback" in plan design in the last two years; 27% have shifted cost to the employee through the deductible; 23% have increased the deductible, while 12% have extended it to coverages not previously subject to the deductible, (8% have done both). In addition, a third of the companies are considering increasing the deductible.

Other plan design changes include increasing the employee's share of the premium (17%; with 20% considering), increasing the employee coinsurance amount (9%; with 22% considering) and revision from reasonable and customary to scheduled benefits (2%; with 8% considering).

Health Promotion and Communication

Physical exams are quite common with half of the participants reporting a pre-employment physical and 17% providing periodic physical exams.

Health promotion programs are quite prevalent and are primarily targeted at smoking cessation (48%), drug and alcohol assistance (50%), and control of high blood pressure (47%).

Twenty percent of the participants provide exercise facilities or subsidized health club membership.

Less than a quarter of the companies have a communications plan specifically for the purpose of controlling medical costs, but 40% report that they are considering it.

Claims Analysis

Claims analysis programs are quite prevalent in the survey group. Thirty-seven percent report conducting general claims analysis to determine trends and problem areas, while 44% review claims for accuracy. One quarter of the companies contract with an outside claims review service such as professional standards review organizations.

Employee Coalitions

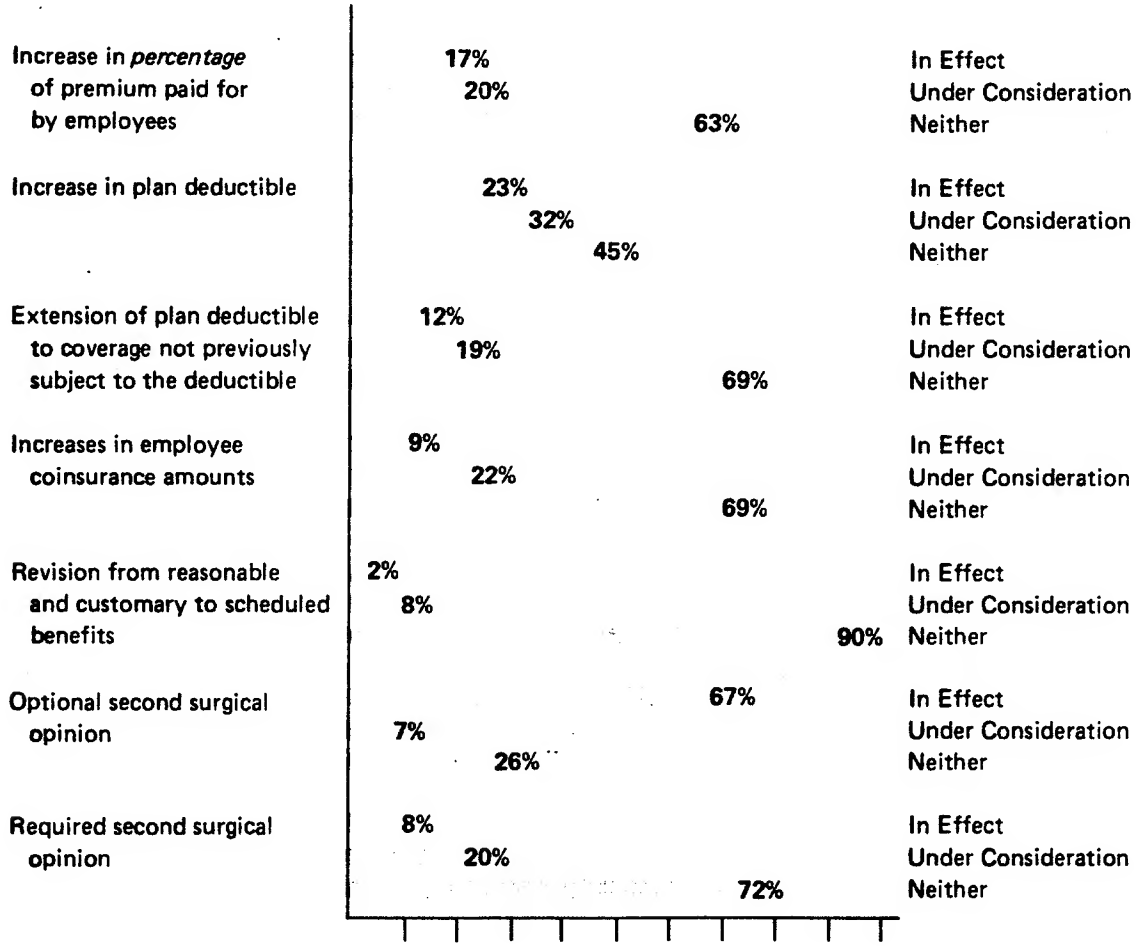
One third of the companies participate in coalitions to control medical costs. Reported purposes of the coalitions are: to operate a peer review program (52%), to operate a health program (45%), to negotiate with providers (44%), and to conduct claims analysis (44%).

I. PLAN DESIGN

Forty-seven percent of health plan design changes shown below were made with some 'other' type of plan changes. Of these, 26% made medical plan improvements, 4% made other plan improvements, and 17% made both medical and other plan improvements. However, 53% of the reported changes were made without any benefits plan improvements.

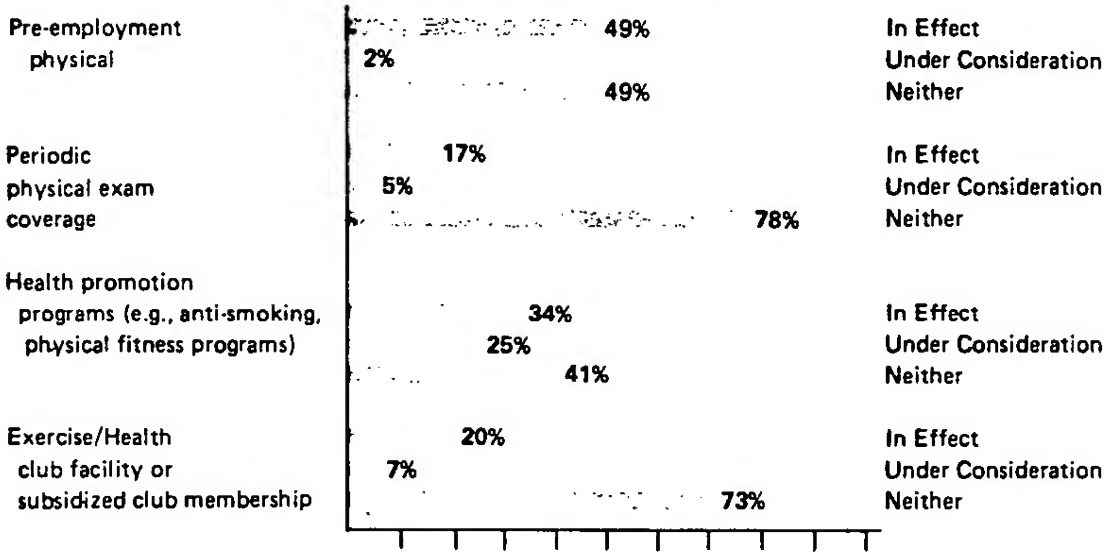
Twenty-seven percent of the participants increased their major medical deductible and/or extended this deductible to other coverage not previously subject to the plan deductible.

Table 4.12 Health Plan Changes to Help Control Medical Costs
Change Undertaken Within Last 2 Years



II. HEALTH PROMOTION

Table 4.13 Employer Health Promotion Programs Designed to Control Medical Costs



Twenty-two percent of those surveyed presently have a specifically stated employee communications program. Forty percent are currently considering this option.

Table 4.14 Employer Communication Programs Designed to Control Medical Costs

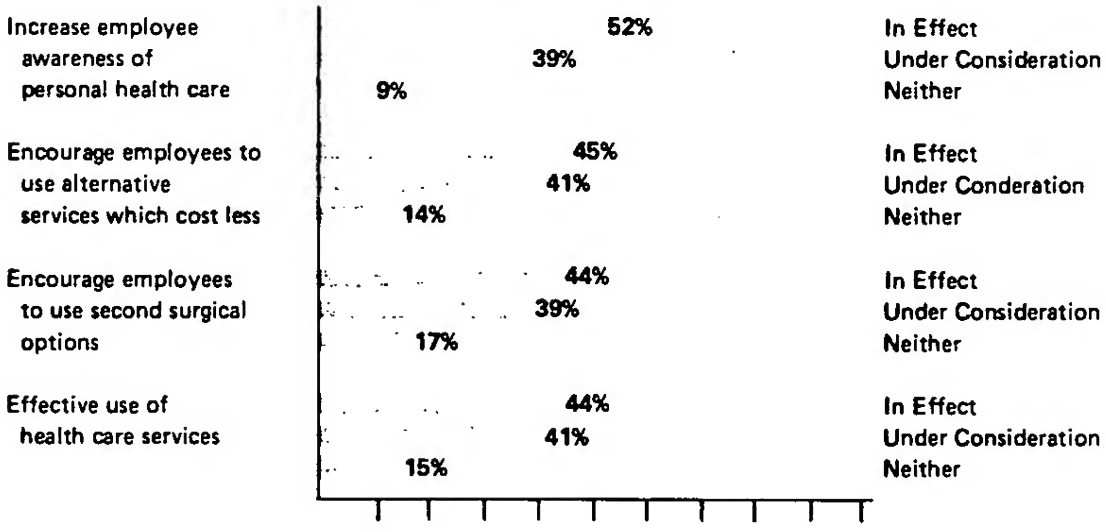
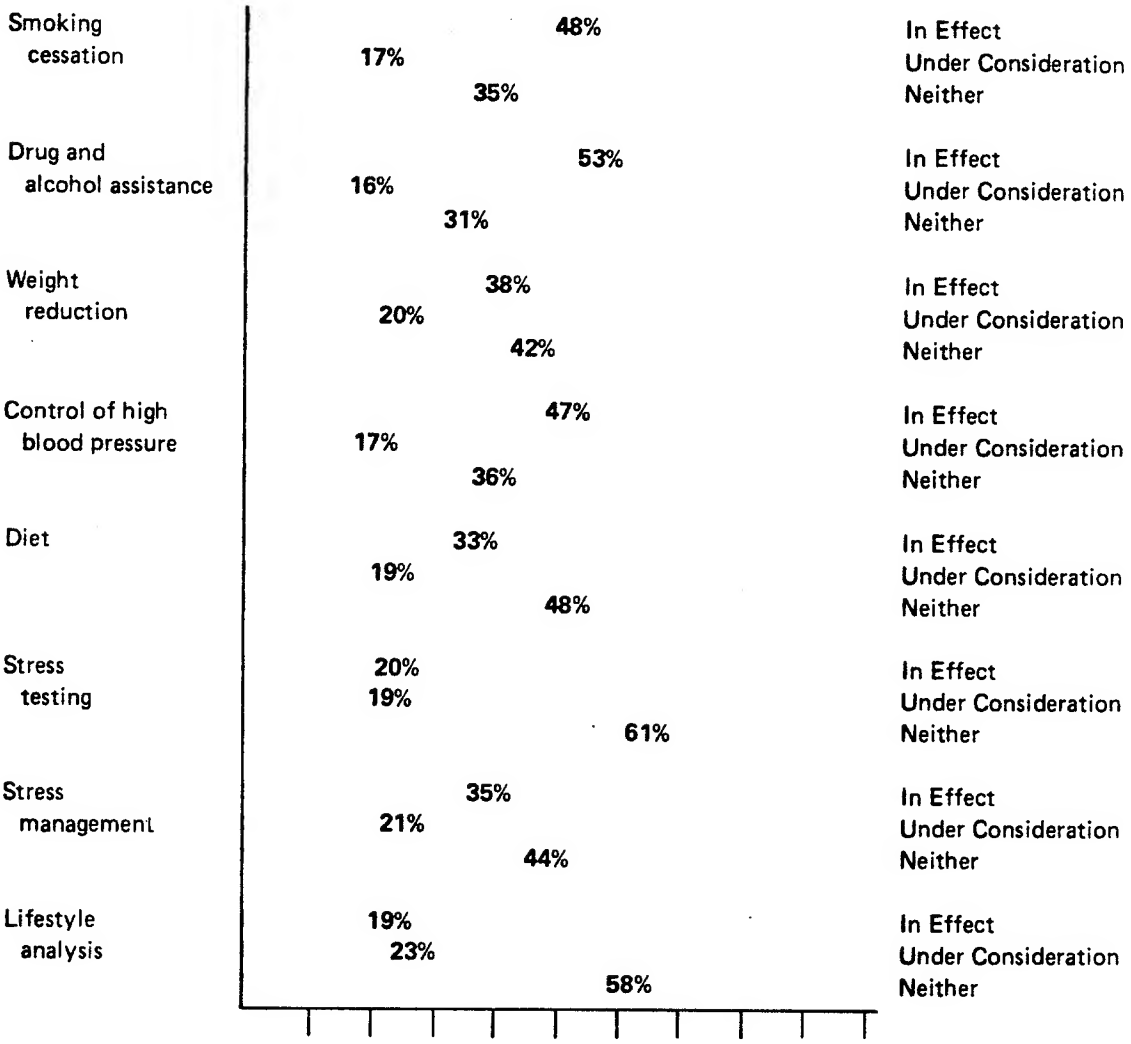


Table 4.15 Features of Employer Health Promotion Programs



Sixty-three percent of the surveyed health promotion programs are operated by company staff, ten percent use an outside agency while 27% use a combination of both.

Most (63%) exercise/health club programs provide facilities at the employers' location while 38% subsidize membership fees of outside facilities.

IV. COST CONTAINMENT COALITIONS

Thirty-one percent of those surveyed participate in a coalition of other organizations for the purpose of medical care cost containment. Thirteen percent are considering such a strategy.

Table 4.19 Employer Coalitions to Help Control Medical Costs

Purposes for Employer Coalitions

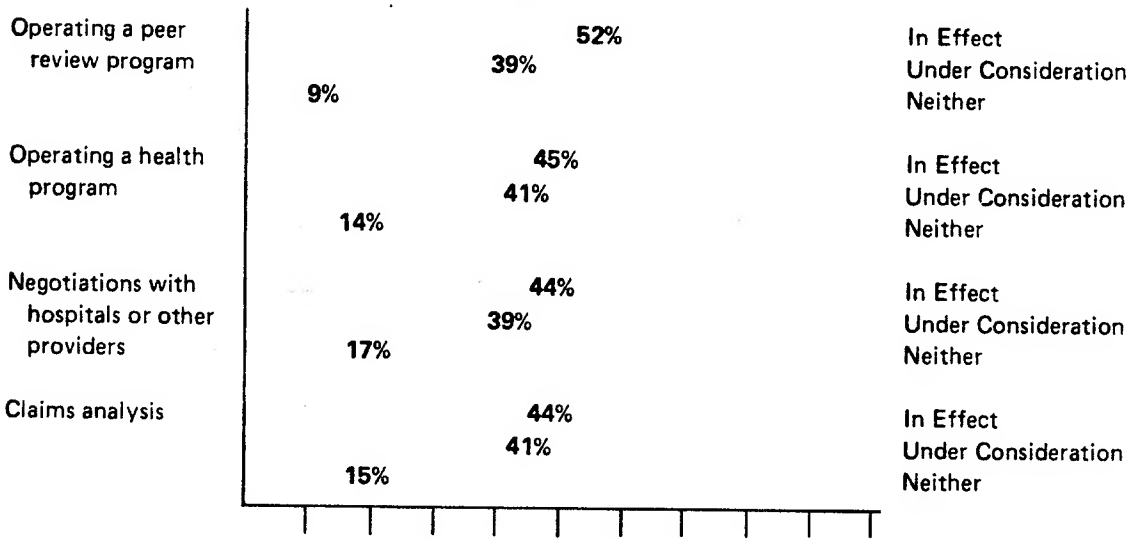


Table 4.16 Percentage of Employees Actively Participating in Health Promotion Program

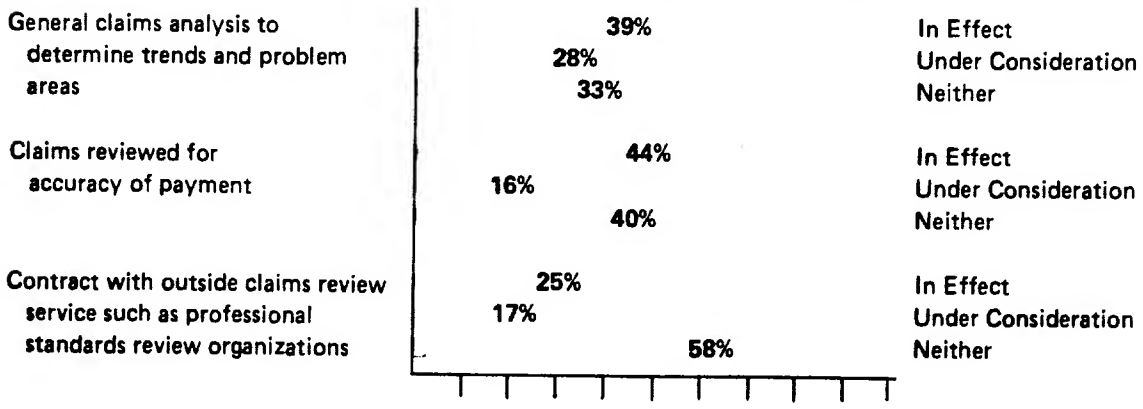
	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	3	12	3	7	6	9
5-9.99	4	16	7	17	11	17
10-14.99	4	16	7	17	11	17
15-24.99	7	28	8	20	15	23
25-49.99	1	4	9	22	10	15
50-74.99	5	20	6	15	11	17
75-100	1	4	1	2	2	2
Total	25	100	41	100	66	100

Table 4.17 Percentage of Employees Actively Participating in Exercise/Health Club Programs

	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	10	23	5	15	15	19
5-9.99	7	16	6	18	13	17
10-14.99	4	9	6	18	10	13
15-24.99	10	23	9	28	19	25
25-49.99	10	23	5	15	15	19
50-100	3	6	2	6	5	7
Total	44	100	33	100	77	100

III. CLAIMS ANALYSIS

Table 4.18 Employer Claims Analysis Programs



Benefit	Indemnity Ben. Low	Service Benefit Low (Standard)	GEHA - KC	POSTAL SUPERVISORS	SAMBA	Foreign Service
Hospital Inpatient	$250/CY (MM) deductible, then 75%	$100/Admission, then 100% for 180 days, then 75%	100% Room and Board; $200/CY (MM) deductible, then 80% for other hospital charges	$165/CY (hospital) deductible, then 100%	$100/confinement, then 100%; 80% without 2nd opinion	$225/CY, then 100% for 31 days, then 80%
Surgery Inpatient Outpatient	$250 CY (MM) deductible, then 75%	$250 CY (MM) deductible, then 75% 75%	$200/CY (MM) deductible, then 80% $200/CY (MM) deductible, then 85%	80% 100%	100%; 80% without 2nd opinion	80% 100%
Major Medical Deductible # per family Coinsurance	$250 $750 per family 75%	$250 2 75%	$200 3 85%	$200 2 75%	$200 2 80%	$175 2 75%
Dental*	No	Yes	No	Minimal	No	Minimal
Stop Loss Per Person Per Family Includes Mental Health	$2,000 $4,000 No	$2,500 No	$2,000 No	$1,000 No	$700 $1400 Outpatient Expenses	100% after $10,000 in covered expenses are incurred Yes
Annual Family Rate	$407	$446	$493	$729	$872	$993

*Plans that provide more than benefits for oral surgery on the jaw, including removal of impacted wisdom teeth, and dental repair of accidental injury are indicated as offering dental coverage. A "minimal" rating indicates that modest benefits are available for routine type services.

Benefit	Association	Indemnity Ben. High Option	GEBA	Service Benefit High Option
Hospital Inpatient	$200/confinement, then 100%	$200/CY (MM) deductible,	100%	$50/Admission, then 100%
Surgery Inpatient Outpatient	80% 100%	$200/CY (MM) deductible, the 80%	$175 CY (MM) deductible, then 100%; 80% without 2nd opinion 100%	80% 100% for facility 80% for physician
Major Medical Deductible # per family Coinsurance	$200 2 80%	$200 $600 per family 80%	$175 $350 per family 80%	$200 2 80%
Dental *	No	Yes	Yes	No
Stop Loss Per Person Per Family Includes Mental Health	$1000 Yes	$2000 $4000 No	$1000 No	$1500 No
Annual Family Rate	$1248	$1308	$1495	$1692

*Plans that provide more than benefits for oral surgery on the jaw, including removal of impacted wisdom teeth, and dental repair of accidental injury are indicated as offering dental coverage. A "minimal" rating indicates that modest benefits are available for routine type services.

Mental Health Inpatient

Plan	After Deductible	Plan Pays Coinsurance	Up to out-of-pocket Limit of	then Plan Pays	Up to Lifetime Maximum of
Aetna-Low	$1,000/CY	75%	$5,000	100%	$50,000
Blues-Low	$100/Admission	75% for 30 days	—	—	$50,000
GEHA-KC	$500/CY	50%	$8,000	100%	$50,000
Postal Supervisors	$800/CY	100% for 31 days, then 50%	$8,000	100%	$50,000
SAMBA	$100/Confinement	100% for 60 days, then 50%	$6,500	100%	$50,000
Foreign Service	$225/CY	100% for 31 days, then 80%	$10,000 in covered expenses incurred *	100%	None
Association	$200/Confinement	100% for 60 days, then 80%	$1,000*	100%	None
Aetna-High	$1,000/CY	80%	$5,000	100%	$50,000
GEBA	$250/Confinement	50%	$8,000	100%	$50,000
Blues-High	$50/Admission	80%	$4,000	100%	$75,000

*Charges for inpatient mental health care accrue toward the Plan's overall catastrophic care benefit.

Mental Health Outpatient

Plan	Major Medical Deductible	Then Plan Pays	Balance of Covered Charges Considered Under Catastrophic Coverage?
Aetna-Low	$250	75% up to $750	No
Blues-Low	$250	75% for 25 visits	No
GEHA-KC	$200	$25 per visit for 30 visits	No
Postal Supervisors	$200	$20 per visit for 50 visits	No
SAMBA	$200	80% of up to $50 per visit NTE 50 visits	Yes
Foreign Service	$175	50% for 50 visits	Yes
Association	$200	50% for 50 visits	Yes
Aetna-High	$200	80% up to $1000	No
GEBA	$175	$25 per visit for 25 visits	No
Blues-High	$200	70% for 50 visits	No

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- The benefit structure is generally comparable with other FEHBP plans with certain significant advantages.
- The overall rate increase is reasonable compared to trends in other FEHBP plans and the economy in general.
- The 1984 rates may be set too high but the Association had no choice given the position taken by Mutual of Omaha.
- The combination of a conservative rate and benefit changes to control costs may well lead to high reserves in 1984 that can be used to offset part of any 1985 rate increase.

In addition to the possible excess reserves that may occur next year, there are other measures that the Association can consider to evolve a more competitive program. The current contract will involve Hay in this review and redesign process during 1984.

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Comparison of Benefits in FEHBP

FEHBP enrollees have felt the dual sting of benefit reductions and substantial premium increases: the former as a by-product of OPM's reaction to the general escalation in the cost of medical care and its attendant budget implications, the latter exacerbated by the realignment of the "big six". These results have been seen by enrollees in both the traditional insurance type plans and by those choosing the alternative HMO-type plans available under the Program.

Attachment B contrasts key components of the benefit structure of the Association Plan with that offered by other selected FEHBP carriers. Included in the comparison are the two Government wide alternatives (Service Benefit Plan, Indemnity Benefit Plan), single agency offerings (Foreign Service Benefit Plan, GEBA [NSA], and SAMBA [FBI]) and the Government Employees Hospital Association Benefit Plan - Kansas City, and the Postal Supervisors Benefit Plan, an offering structured like your own. The plans are displayed in ascending order based on the annual cost to employees for Self and Family coverage. Mental health benefit provisions are shown in Attachment C.

The range of annual employee premium amounts displayed in the chart runs from $407 to $1692 per year. At first glance, one would expect to see a significant variance in the level of protection available at different prices. However, such is not the case. The less expensive plans do involve more out-of-pocket exposure for an enrollee, but, in most instances not a substantial variation in the benefits provided.

With the reductions for 1984, the Association's benefit structure becomes, overall, typical of other FEHBP offerings in most areas. Specifically:

Hospital Inpatient: With the exception of GEBA all of the charted plans involve a flat dollar out-of-pocket payment. Your Plan's level of reimbursement after that outlay, 100%, is generous, however, your hospital copayment is assessed against each confinement whereas five of the other plans either view the copayment as a part of the Major Medical deductible or assess it once in a calendar year. The Association's inpatient coverage overall is typical.

Surgery: Your Plan's practice of cost sharing imposed for surgery performed on an inpatient basis along with encouragement of outpatient surgery through 100% reimbursement follows the pattern of most FEHBP carriers. You should expect to see cost savings and improved utilization patterns as a result of this benefit change.

Major Medical: The $200 deductible is average. The 80% coinsurance level generally is more generous than less expensive plans and typical of the more expensive offerings.

Dental: The Association Plan provides no dental coverage which is an item many employees perceive as a valued benefit, even though it can be provided for a fairly minimal cost investment.

Stop Loss: Your Plan's catastrophic coverage is a strong point. Not only does it provide protection after $1,000 out-of-pocket, a relatively modest stop loss point, but it includes covered charges for mental and nervous conditions as well. The latter is atypical for FEHBP carriers.

Mental Health: The Association's mental health coverage is among the most comprehensive now available to federal employees, especially on an inpatient basis. Not only is there no lifetime maximum imposed, but out-of-pocket expenses for the enrollee are capped at the $1,000 stop loss level. Only the Foreign Service Benefit Plan approaches the same level of inpatient protection. The outpatient coverage does impose a 50 visit maximum per calendar year, which in most instances, provides more than adequate protection for a covered life. The fact that the 50% out-of-pocket coinsurance expense accrues toward the $1,000 stop loss limit makes the benefit generous.

Comparison of Premiums in FEHBP

Tables one and two show the total annual cost of all of the plans available to agency employees in the Washington area as well as the plans summarized in Attachment B. The Association self only premium is about average but the family premium is in the middle-high range. Because the Association benefits are better than the other plans in the same premium range, the premium is competitive with the higher cost plans. However, the typical employee who does not anticipate unusual expenses can clearly see substantial savings by moving to one of the low cost plans with good benefits.

The two best low cost plans are the "other" GEHA and the Blue Cross low (standard) option. An employee comparing either of these two plans to the Association plan will observe savings of around $800 in premium in the family plan. Unless heavy mental and nervous expenses are incurred, an employee will rarely receive $800 more in benefits from the agency plan than from either of the other two.

Table 1

1984 Federal Employees Health Benefits Program

Annual Cost Self and Family Option

Insurance Type Plans

	Health Benefits Cost	Annual Associate Dues
Postmasters - Low	$246	$25
Mailhandlers - Low	385	30
Aetna - Low	407	0
Blues - Low	446	0
GEHA	493	35*
Mailhandlers - High	515	30
Postal Supervisors	729	25
Alliance	865	27
SAMBA	872	0
Foreign Service	993	0
NFFE	1003	25
NALC	1190	36
NTEU	1195	30
APWU	1207	35
Government Employees Health Assn.	1248	0
Aetna - High	1308	0
NAGE	1390	25
GEBA	1495	0
Postmasters - High	1631	25
Blues - High	1692	0

D.C. Area Health Maintenance Type Organizations

GHA - Low	$731	0
MD IPA	869	0
Kaiser Georgetown	1049	0
Choice Healthcare	1120	0
GHA - High	1203	0
HealthPlus	1216	0
George Washington	1349	0

*One time only.

Table 2

1984 Federal Employees Health Benefits Program

Annual Cost Self Only Option

Insurance Type Plans

	Health Benefits Cost	Annual Associate Dues
Postmasters - Low	$ 101	$25
Mailhandlers - Low	163	30
Mailhandlers - High	181	30
Blues - Low	187	0
Aetna - Low	191	0
Alliance	225	27
SAMBA	264	0
GEHA	267	35*
Foreign Service	315	0
NFFE	415	25
Government Employees Health Assn.	429	0
Postal Supervisors	492	25
NTEU	523	30
NAGE	551	25
GEBA	574	0
APWU	587	35
NALC	637	36
Postmasters - High	772	25
Blues - High	781	0
Aetna - High	833	0

D.C. Area Health Maintenance Type Organizations

MD-IPA	$ 218	0
GHA - Low	222	0
Kaiser Georgetown	351	0
Choice Healthcare	399	0
GHA - High	404	0
HealthPlus	409	0
George Washington	437	0

*One time only.

Appropriateness of Association Premiums

In 1984 the Association premium increased 16%. This net increase is the same as the average increase of the largest plans in the FEHB Program. In fact, two of the more popular plans, GEHA and Aetna high option, had increases of 30% and 38%, respectively. However, the Association 16% premium increase was effected at the expense of a 9% reduction in benefits. The other plans had already absorbed similar reductions in 1982.

Even though the total Association premium increase is average within the FEHB Program, the increase to the employee is greater than average because of the change in composition of the six largest plans that determine the Government contribution. In 1984, NALC was replaced in the big-six by GEHA. Since the GEHA Plan had a much lower premium than NALC, the average Government contribution only went up 10%. As a result, employees in most plans, such as the Association Plan, with average increases, have an above average employee share increase. In summary, the effect on the employee breaks down as follows:

o	Premium increase for 1983 benefit levels-	25%
o	Benefit reduction -	(9%)
o	Big six effect -	8%
o	Total increase -	24%

The premium increase to continue 1983 benefits, before being offset for 1984 benefit reductions, was significantly above the average FEHBP increases as well as the typical private sector increases. The primary reason for this high increase was a deterioration of experience in the last half of 1982. Last year, at the time that rates were set, Mutual of Omaha had expected the early 1982 trends to continue and set the 1983 premium on that basis. However, the monthly payments took a sharp turn upward. Compared to the last half of 1981, overall costs in 1982 were up 37% including an increase in hospital Room and Board cost of 62%. The effect of the $600,000 claim for one case must not be overlooked. If the last half of 1982 trends are adjusted for the $600,000 claim, the overall increase would have been 26% rather than 37%.

The way that Mutual of Omaha constructs premiums is to predict each future year's claims as a percentage increase over the last year. Thus, the unusual effect of late 1982, notably the $600,000 case, is expected to be repeated in 1983 and 1984. If the $600,000 case was truly atypical, it is quite possible that experience will be better in late 1983. The effect would be to produce a much lower rate increase in 1985. This effect, coupled with the cost saving measures, could well put the 1985 premium increase at a much lower level than other plans.

The Office of Personnel Management (OPM) concluded that the 1984 premium increase was excessive. While the OPM reasons for this conclusion were not stated, they probably were concerned about over-reaction to a few months of poor experience. Our review of the incurred claims supports the OPM conclusion. If the temporary adverse experience is discounted, it is likely that the 1984 premium will generate excess reserves which can be used to hold down the 1985 premiums.

One important continuing reason for a relatively high rate for the Association is the existence of the very liberal mental and nervous benefits. At one time the Association mental and nervous benefits were typical of the FEHB Program. However, other plans, particularly the Government-wide plans, cut their benefits substantially while the Association plan provisions, particularly in the hospital, stayed at almost full insurance. As a result, 13% to 15% of Association benefits are expended for mental and nervous benefits compared to around 5% for the other FEHB plans.

Table three illustrates the position of the Plan family premiums relative to three of the most popular options in 1981 through 1984. In 1982 the Association family rate rose 50% resulting in a very adverse shift in competitive position. However, as a result of the shifts in other plans in the last two years, the Association's relative position has about returned to the 1981 position. While the Association premium is more than double the lowest cost full benefit plan, GEHA, the premium is well below the most popular plan, the Blues, and has now dropped below the second most popular plan, Aetna.

Table 3

Self and Family Biweekly Rates - 1981 through 1984

	1981	1982	1983	1984
Blues	$30.52	$41.77	$54.50	$65.06
Aetna	15.11	15.66	26.88	50.31
GEHA	10.47	13.00	13.65	18.96
Association	20.49	30.38	38.57	48.00

Alternatives to Consider

Hay will present alternatives for consideration that may be pursued in 1985 to help mitigate continued premium acceleration. We will explore the pros and cons of each alternative as well as the feasibility of the agency implementing the alternatives. Although we will include other options agency management might elect, we suggest we examine the following items:

- limited plan modification;
- introduction of dental benefits;
- creation of a low option;
- a special Government contribution for employees restricted to the Association plan;
- alternative funding mechanisms, such as minimum premium arrangements;
- purchase of re-insurance to ameliorate the effect of unusual claims;
- a campaign to educate Association plan enrollees as to effective use of health care; and
- consideration of other underwriters.

Most employers are continuing efforts to control spiraling medical benefits costs (reported at an average cost increase of 25% in each of the last two years). Primary strategies are:

- Changing Plan Design,
- Operating Health Promotion and Communication Programs,
- Conducting Claims Analysis, and
- Organizing Employer Coalitions

Many employers participate in cost containment coalitions to assist them in both operating health and communication programs and in conducting claims analysis.

Plan Design

One-third of the participants have made some "cutback" in plan design in the last two years; 27% have shifted cost to the employee through the deductible; 23% have increased the deductible, while 12% have extended it to coverages not previously subject to the deductible, (8% have done both). In addition, a third of the companies are considering increasing the deductible.

Other plan design changes include increasing the employee's share of the premium (17%; with 20% considering), increasing the employee coinsurance amount (9%; with 22% considering) and revision from reasonable and customary to scheduled benefits (2%; with 8% considering).

Health Promotion and Communication

Physical exams are quite common with half of the participants reporting a pre-employment physical and 17% providing periodic physical exams.

Health promotion programs are quite prevalent and are primarily targeted at smoking cessation (48%), drug and alcohol assistance (50%), and control of high blood pressure (47%).

Twenty percent of the participants provide exercise facilities or subsidized health club membership.

Less than a quarter of the companies have a communications plan specifically for the purpose of controlling medical costs, but 40% report that they are considering it.

Claims Analysis

Claims analysis programs are quite prevalent in the survey group. Thirty-seven percent report conducting general claims analysis to determine trends and problem areas, while 44% review claims for accuracy. One quarter of the companies contract with an outside claims review service such as professional standards review organizations.

Employee Coalitions

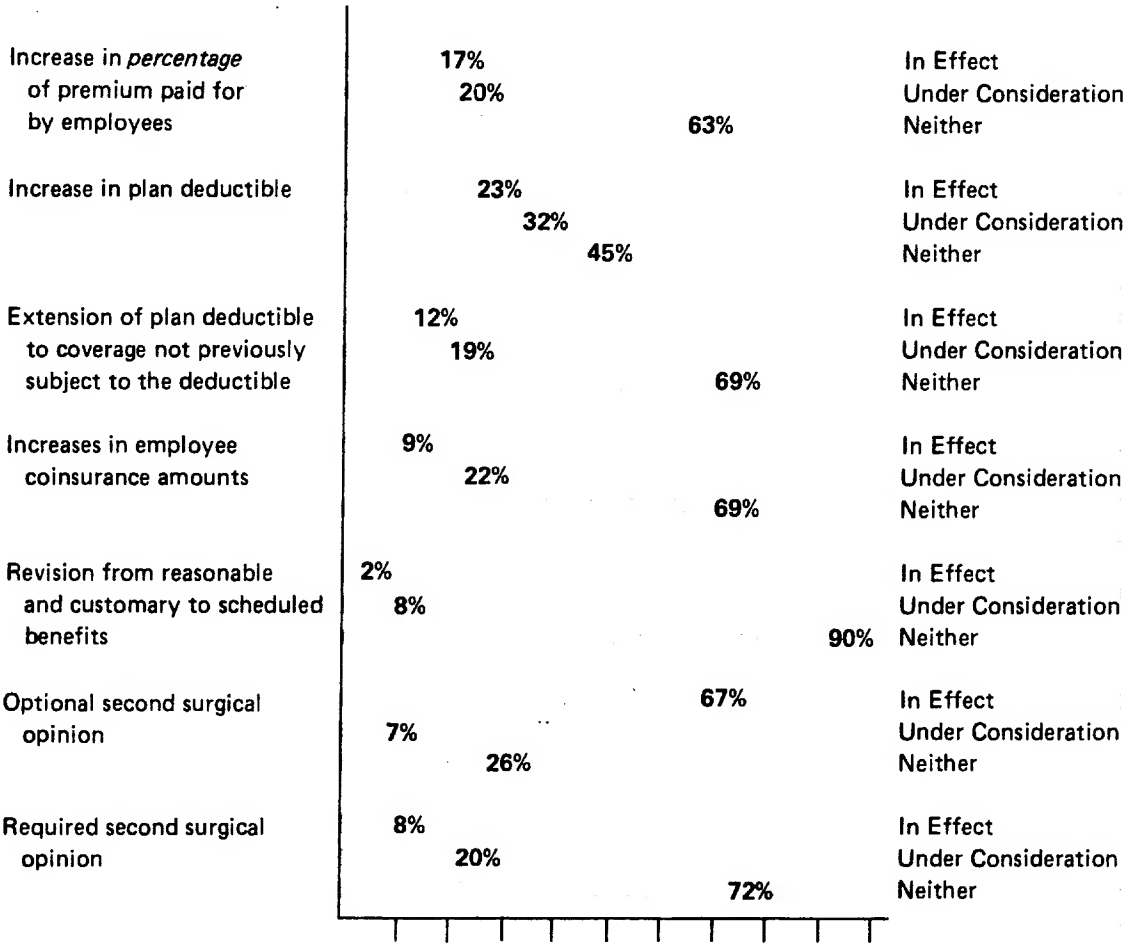
One third of the companies participate in coalitions to control medical costs. Reported purposes of the coalitions are: to operate a peer review program (52%), to operate a health program (45%), to negotiate with providers (44%), and to conduct claims analysis (44%).

I. PLAN DESIGN

Forty-seven percent of health plan design changes shown below were made with some 'other' type of plan changes. Of these, 26% made medical plan improvements, 4% made other plan improvements, and 17% made both medical and other plan improvements. However, 53% of the reported changes were made without any benefits plan improvements.

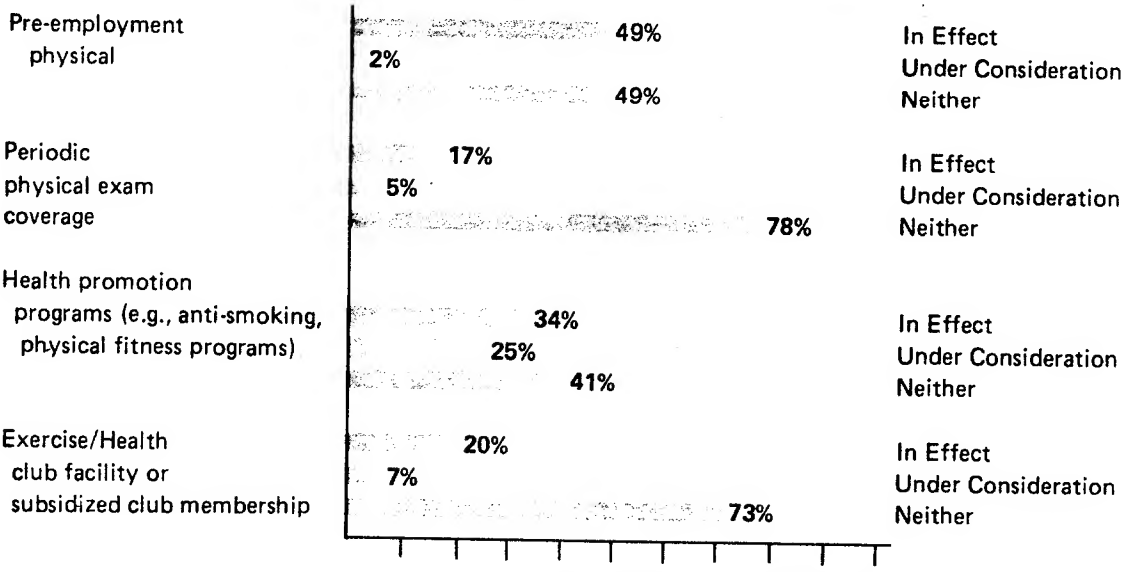
Twenty-seven percent of the participants increased their major medical deductible and/or extended this deductible to other coverage not previously subject to the plan deductible.

Table 4.12 Health Plan Changes to Help Control Medical Costs
Change Undertaken Within Last 2 Years



II. HEALTH PROMOTION

Table 4.13 Employer Health Promotion Programs Designed to Control Medical Costs



Twenty-two percent of those surveyed presently have a specifically stated employee communications program. Forty percent are currently considering this option.

Table 4.14 Employer Communication Programs Designed to Control Medical Costs

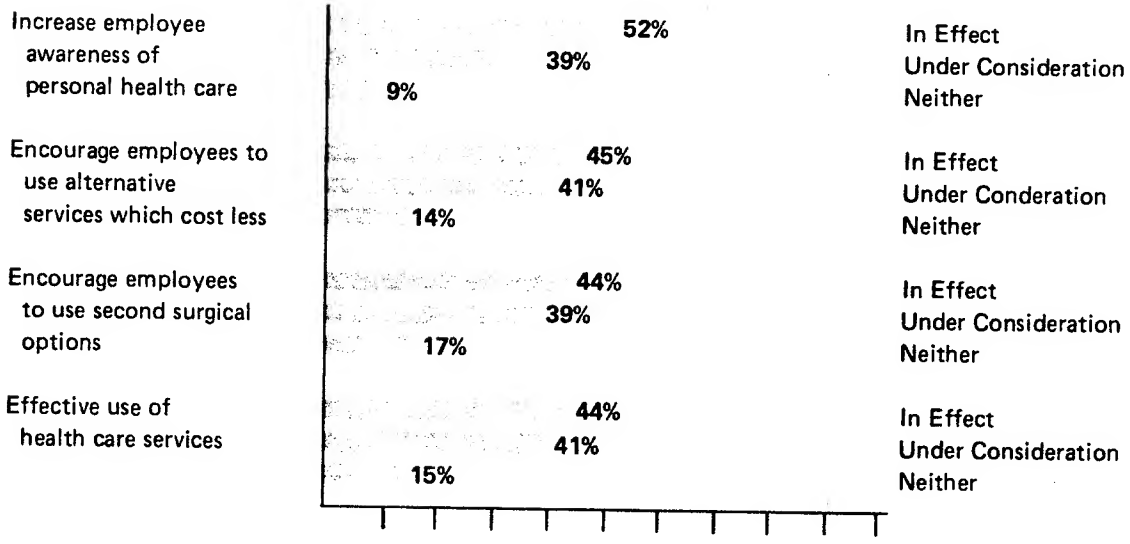
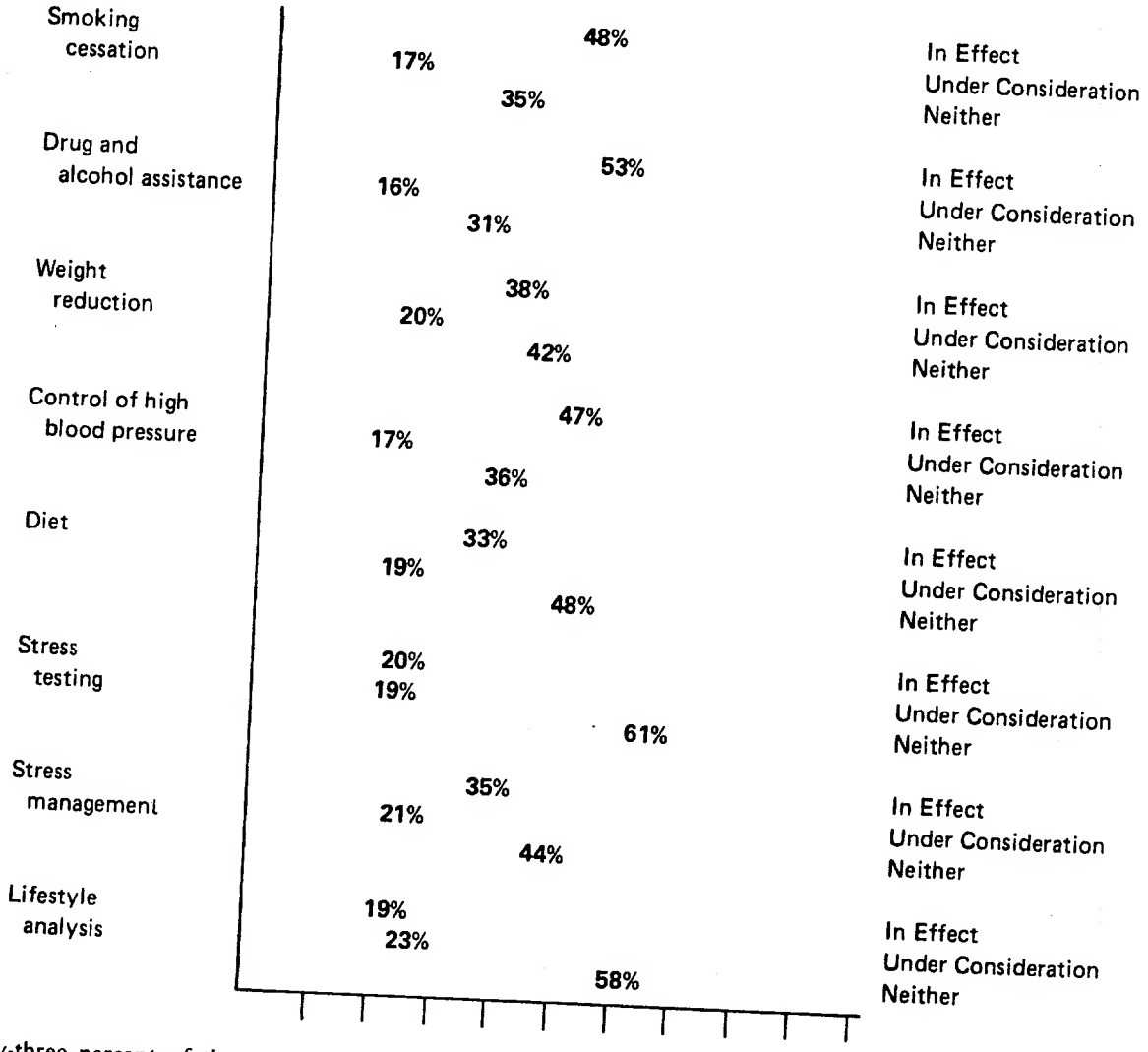


Table 4.15 Features of Employer Health Promotion Programs



Sixty-three percent of the surveyed health promotion programs are operated by company staff, ten percent use an outside agency while 27% use a combination of both.

Most (63%) exercise/health club programs provide facilities at the employers' location while 38% subsidize membership fees of outside facilities.

Table 4.16 Percentage of Employees Actively Participating in Health Promotion Program

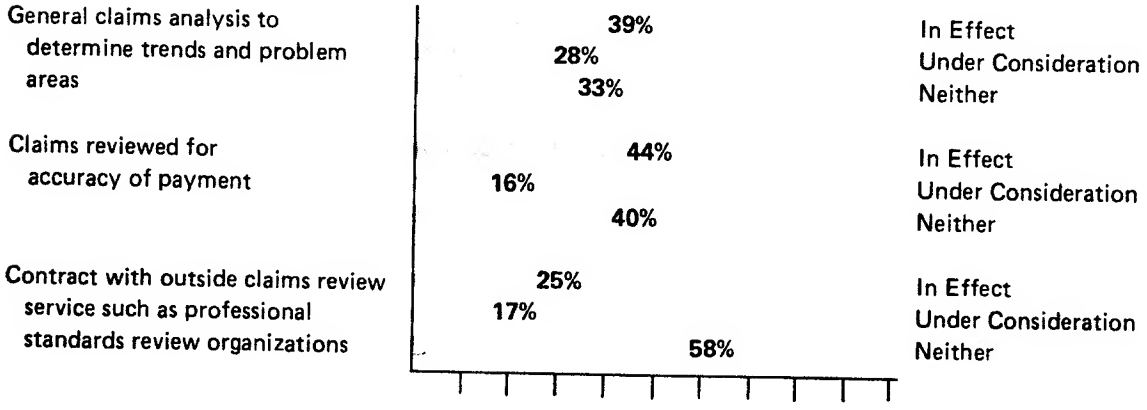
	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	3	12	3	7	6	9
5-9.99	4	16	7	17	11	17
10-14.99	4	16	7	17	11	17
15-24.99	7	28	8	20	15	23
25-49.99	1	4	9	22	10	15
50-74.99	5	20	6	15	11	17
75-100	1	4	1	2	2	2
Total	25	100	41	100	66	100

Table 4.17 Percentage of Employees Actively Participating in Exercise/Health Club Programs

	Industrial		Fin./Svc.		Total	
	No.	%	No.	%	No.	%
⩽ 1-4.99	10	23	5	15	15	19
5-9.99	7	16	6	18	13	17
10-14.99	4	9	6	18	10	13
15-24.99	10	23	9	28	19	25
25-49.99	10	23	5	15	15	19
50-100	3	6	2	6	5	7
Total	44	100	33	100	77	100

III. CLAIMS ANALYSIS

Table 4.18 Employer Claims Analysis Programs

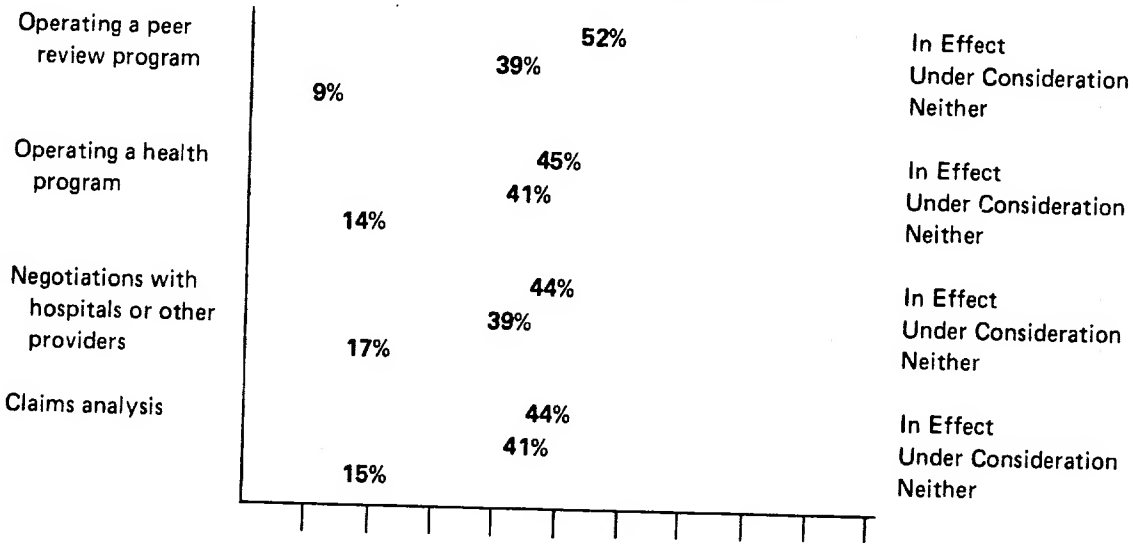


IV. COST CONTAINMENT COALITIONS

Thirty-one percent of those surveyed participate in a coalition of other organizations for the purpose of medical care cost containment. Thirteen percent are considering such a strategy.

Table 4.19 Employer Coalitions to Help Control Medical Costs

Purposes for Employer Coalitions



Benefit	Indemnity Ben. Low	Service Benefit Low (Standard)	GEHA - KC	POSTAL SUPERVISORS	SAMBA	Foreign Service
Hospital Inpatient	$250/CY (MM) deductible, then 75%	$100/Admission, then 100% for 180 days, then 75%	100% Room and Board; $200/CY (MM) deductible, then 80% for other hospital charges	$165/CY (hospital) deductible, then 100%	$100/confinement, then 100%; 80% without 2nd opinion	$225/CY, then 100% for 31 days, then 80%
Surgery Inpatient Outpatient	$250 CY (MM) deductible, then 75%	$250 CY (MM) deductible, then 75% 75%	$200/CY (MM) deductible, then 80% $200/CY (MM) deductible, then 85%	80% 100%	100%; 80% without 2nd opinion	80% 100%
Major Medical Deductible	$250	$250	$200	$200	$200	$175
# per family	$750 per family	2	3	2	2	2
Coinsurance	75%	75%	85%	75%	80%	75%
Dental	No	Yes	No	Minimal	No	Minimal
Stop Loss Per Person	$2,000	$2,500	$2,000	$1,000	$700	100% after $10,000 in covered expenses are incurred
Per Family	$4,000				$1400	
Includes Mental Health	No	No	No	No	Outpatient Expenses	Yes
Annual Family Rate	$407	$446	$493	$729	$872	$993

2272 2993

Benefit	Association	Indemnity Ben. High Option	GEBA	Service Benefit High Option
Hospital Inpatient	$200/confinement, then 100%	$200/CY (MM) deductible,	100%	$50/Admission, then 100%
Surgery Inpatient	80%	$200/CY (MM) deductible, the 80%	$175 CY (MM) deductible, then 100%; 80% without 2nd opinion	80%
Outpatient	100%		100%	100% for facility 80% for physician
Major Medical Deductible	$200	$200	$175	$200
# per family	2	$600 per family	$350 per family	2
Coinsurance	80%	80%	80%	80%
Dental	No	Yes	Yes	No
Stop Loss Per Person	$1000	$2000	$1000	$1500
Per Family		$4000		
Includes Mental Health	Yes	No	No	No
Annual Family Rate	$1248	$1308	$1495	$1692

2248 1308 2495 3192

Mental Health Inpatient

Plan	After Deductible	Plan Pays Coinsurance	Up to out-of-pocket Limit of	then Plan Pays	Up to Lifetime Maximum of
Aetna-Low	$1,000/CY	75%	$5,000	100%	$50,000
Blues-Low	$100/Admission	75% for 30 days	—	—	$50,000
GEHA-KC	$500/CY	50%	$8,000	100%	$50,000
Postal Supervisors	$800/CY	100% for 31 days, then 50%	$8,000	100%	$50,000
SAMBA	$100/Confinement	100% for 60 days, then 50%	$6,500	100%	$50,000
Foreign Service	$225/CY	100% for 31 days, then 80%	$10,000 in covered expenses incurred	100%	None
Association	$200/Confinement	100% for 60 days, then 80%	$1,000	100%	None
Aetna-High	$1,000/CY	80%	$5,000	100%	$50,000
GEBA	$250/Confinement	50%	$8,000	100%	$50,000
Blues-High	$50/Admission	80%	$4,000	100%	$75,000

Mental Health Outpatient

Plan	Major Medical Deductible	Then Plan Pays	Balance of Covered Charges Considered Under Catastrophic Coverage?
Aetna-Low	$250	75% up to $750	No
Blues-Low	$250	75% for 25 visits	No
GEHA-KC	$200	$25 per visit for 30 visits	No
Postal Supervisors	$200	$20 per visit for 50 visits	No
SAMBA	$200	80% of up to $50 per visit NTE 50 visits	Yes
Foreign Service	$175	50% for 50 visits	Yes
Association	$200	50% for 50 visits	Yes
Aetna-High	$200	80% up to $1000	No
GEBA	$175	$25 per visit for 25 visits	No
Blues-High	$200	70% for 50 visits	No